

2011 Benefits

Lake County Board of County Commissioners 64550

The Lake County Board of County Commissioners believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueChoice 730 PPO	BlueCare 15 HMO
Deductible (DED) (Per Person/Family Agg)		Not Applicable
In-Network	\$750 / \$2,250	
Out-of-Network	Combined w/In-Ntwk	
Coinurance (Member Responsibility)		Not Applicable
In-Network	20%	
Out-of-Network	40%	
Out of Pocket Maximum (Per Person/Family Agg)	Includes only Coins; Excludes Rx	Includes all Copays (including Rx)
In-Network	\$2,000 / \$6,000	\$2,000 / \$4,000
Out-of-Network	Combined w/In-Ntwk	Not Applicable
Lifetime Maximum	No Maximum	No Maximum
PROFESSIONAL PROVIDER SERVICES		
Allergy Injections (for testing, see place of service)		
In-Network Family Physician	\$0	\$0
In-Network Specialist	\$0	\$0
Out-of-Network	DED + 40%	Not Covered
E-Office Visit Services		
In-Network Family Physician	\$20	\$20
In-Network Specialist	\$35	\$35
Out-of-Network	DED + 40%	Not Covered
Office Services		
In-Network Family Physician	\$20	\$20
In-Network Specialist	\$35	\$35
Out-of-Network	DED + 40%	Not Covered
Provider Services at Hospital and ER		
In-Network Family Physician	DED + 20%	\$0
In-Network Specialist	DED + 20%	\$0
Out-of-Network	DED + 40%	Not Covered
Provider Services at Other Locations		
In-Network Family Physician	DED + 20%	\$0
In-Network Specialist	DED + 20%	\$0
Out-of-Network	DED + 40%	Not Covered
Radiology, Pathology and Anesthesiology Provider Services at Hospital or Ambulatory Surgical Center		
In-Network Specialist	DED + 20%	\$0
Out-of-Network	DED + 40%	Not Covered
PREVENTIVE CARE		
Adult Wellness Office Services		
In-Network Family Physician	\$20	\$20
In-Network Specialist	\$35	\$35
Out-of-Network	40% (No DED)	Not Covered
Colonoscopies Routine screening only for age 50+ covered at 100% of allowed amount; In and Out of Network. With diagnosis, subject to applicable deductible, coinsurance or copays.		
In-Network	20% (No DED)	See Location of Service
Out-of-Network	40% (No DED)	Not Covered
Mammograms (Routine and Dx)		
In-Network	\$0	\$0
Out-of-Network	\$0	Not Covered
Well Child Office Visits (No BPM**)		
In-Network Family Physician	\$0	\$0
Well Child Office Visits, continued		
In-Network Specialist	\$0	\$0
Out-of-Network	40% (No DED)	Not Covered
EMERGENCY/URGENT/CONVENIENT CARE		
Ambulance		
In-Network	No Maximum (per day)	No Maximum (per day)
Out-of-Network	DED + 20%	\$0
	In-Ntwk DED + 20%	Not Covered



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Convenient Care Centers (CCC) In-Network Out-of-Network	\$20 DED + 40%	\$20 Not Covered
Emergency Room Facility Services (also see Professional Provider Services) In-Network Out-of-Network	\$50 \$50	\$100 \$100
Urgent Care Centers (UCC) In-Network Out-of-Network	\$20 DED + 40%	\$30 Not Covered
FACILITY SERVICES - HOSP/SURG/ICL/IDTF Unless otherwise noted, physician services are in addition to facility services. See Professional Provider Services.		
Ambulatory Surgical Center In-Network Out-of-Network	DED + 20% DED + 40%	\$200 Not Covered
Independent Clinical Lab In-Network (Quest Labs) Out-of-Network	20% (No DED) 40% (No DED)	\$0 Not Covered
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services) In-Network - Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine) In-Network - Other Diagnostic Services (e.g. X-ray) Out-of-Network	\$35 \$35 DED + 40%	\$200 \$15 Not Covered
Inpatient Hospital (per admit) In-Network Out-of-Network	DED + 20% DED + 40%	\$200 per Day up to \$1,000 Not Covered
Outpatient Hospital (per visit) In-Network Out-of-Network	DED + 20% DED + 40%	\$200 Not Covered
Therapy at Outpatient Hospital In-Network Out-of-Network	DED + 20% DED + 40%	\$20 Not Covered
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Hospitalization In-Network Out-of-Network	DED + 20% DED + 40%	\$200 per Day up to \$1,000 Not Covered
Outpatient Hospitalization (per visit) In-Network Out-of-Network	DED + 20% DED + 40%	\$200 Not Covered
Provider Services at Hospital and ER In-Network Family Physician or Specialist Out-of-Network Provider	\$50 \$50	\$0 Not Covered
Physician Office Visit In-Network Family Physician or Specialist Out-of-Network Provider	\$20 / \$35 DED + 40%	\$20 / \$35 Not Covered
Emergency Room Facility Services (per visit) In-Network Out-of-Network	\$50 \$50	\$100 \$100
Provider Services at Locations other than Hospital and ER In-Network Family Physician In-Network Specialist Out-of-Network Provider	DED + 20% DED + 20% DED + 40%	\$0 \$0 Not Covered
OTHER SPECIAL SERVICES AND LOCATIONS		
Advanced Imaging Services in Physician's Office In-Network Family Physician In-Network Specialist Out-of-Network	\$20 \$35 DED + 40%	\$0 \$0 Not Covered
Birthing Center In-Network Out-of-Network	DED + 20% DED + 40%	\$0 Not Covered
Diabetic Equipment and Supplies* In-Network Out-of-Network	DED + 20% DED + 40%	\$0 Not Covered
Durable Medical Equipment, Prosthetics, Orthotics BPM In-Network Out-of-Network	Enteral Formulas:\$2,500 All Other: No Maximum DED + 20% DED + 40%	Enteral Formulas:\$2,500 All Other: No Maximum \$0 Not Covered

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueChoice 730 PPO	BlueCare 15 HMO
Home Health Care BPM In-Network Out-of-Network	30 Visits DED + 20% DED + 40%	40 Visits \$0 Not Covered
Hospice LTM In-Network Out-of-Network	No Maximum DED + 20% DED + 40%	No Maximum \$0 Not Covered
Outpatient Therapy BPM (Combined Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies) In-Network Out-of-Network	60 Visits DED + 20% DED + 40%	No Maximum. Auth Req for Therapy \$20 Not Covered
Spinal Manipulations BPM In-Network Out-of-Network	26 Spinal Manipulations DED + 20% DED + 40%	\$35 Not Covered
Skilled Nursing Facility BPM In-Network Out-of-Network	90 days DED + 20% DED + 40%	90 days \$0 Not Covered
PRESCRIPTION DRUGS		
In-Network		
Retail (30 days) Generic/Preferred Brand/Non-Preferred	\$15 / \$25 / \$40	\$15 / \$25 / \$40
Mail Order (90 days) Generic/Preferred Brand/Non-Preferred	\$30 / \$50 / \$80	\$30 / \$50 / \$80

* Diabetic Supplies (lancets, strips, etc.) are covered under the Rx benefit except when the group carves out pharmacy. When pharmacy is carved out, they are available through DME. Diabetic Equipment (insulin pumps, tubing) are always covered under the medical benefit.

** BPM means **B**enefit **P**eriod (calendar year) **M**aximum and runs from Jan 1 – Dec 31

This is not an insurance contract or Benefit Booklet. The above Benefit Summary is only a partial description of the many benefits and services covered by Blue Cross and Blue Shield of Florida, Inc., an independent licensee of the Blue Cross and Blue Shield Association. For a complete description of benefits and exclusions, please see Blue Cross and Blue Shield of Florida's Benefit Booklet and Schedule of Benefits; their terms prevail.